SHIR HASHIRIM
MONTESSORI SCHOOL

IMMUNIZATION

Admission Process Forms 3/4

State law requires that all children entering school be immunized against the following:

NUMBER OF IMMUNIZATIONS REQUIRED TO ENTER, BY AGE OF CHILD

	CHILD CARE					SCHOOL		
	2-3 Months	4-5 Months	6-14 Months	15-17 Months	18+ Months	4-6 Years	7-17 Years	7th Grade
Polio (OPV/IPV)	1	2	2	3	3	4[1]	4[b]	
DTP/DtaP	1	2	3	3	4	5[a]	3[b]	
Td Booster								[1[c]]
MMR				1	1	2[d]	1[d]	2[d]
Hepatitis B	1	2	2	2	3	3		3[e]
Hib	1	2	2	1[f]	1[f]			
Varicella					1[g]	1[g]		

a This number includes kindergarten boosters. If your child is 4-6 years old, entry requirements are met with only 3 polio and 4 DTPs if at least one polio and one DTP dose were after your child's fourth birthday.
b For children 7-17 years old, entry requirements are met with only 3 polio and 3 DTP or DT/Td if at least one polio and DTP or DT/Td were after your child's 2nd birthday. For students age 7 and older, pertussis immunization is not required.
c A Td booster is recommended but not required.
d One dose on or after the first birthday is required for grades 1-6 and 8-12. Mumps immunization is not required for students age 7 and older.
e Two doses of the 2-dose formulation along with provider documentation that the 2-dose formulation was used for both doses and both doses were received at age 11-15 years will also fulfill this requirement.
f One dose must be on or after the 1st birthday regardless of any doses received earlier. The Hib requirement applies only to child care children under age 4 years and 6 months.
g If a child had chickenpox disease, ask your doctor to note it on the immunization record to meet the requirement.

If your child's record is missing some doses, please contact your doctor or clinic now to obtain the full immunization record or any doses needed. If your child recently received immunizations and needs an immunization later in the year, he/she can be allowed to attend, provided you get the remaining doses when they become due.

The intent of the law is to protect California children from the dangers of diseases that are preventable by immunization.

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

PHYSICIAN'S REPORT—CHILD CARE CENTERS
(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____, born _____ is being studied for readiness to enter
(NAME OF CHILD) (BIRTH DATE)

_____ . This Child Care Center/School provides a program which extends from ____ : ____
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to _____ a.m./p.m. , _____ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

_____ _____
(SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE) (TODAY'S DATE)

PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing: Allergies: medicine:

Vision: insect stings:

Developmental: food:

Language/Speech: asthma:

other:

Other (Include behavioral concerns):

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	
HEPATITIS B	/ /	/ /	/ /		
VARICELLA (CHICKENPOX)	/ /	/ /			

SCREENING OF TB RISK FACTORS (listing on reverse side)

☐ Risk factors not present; TB skin test not required.

☐ Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
___ Communicable TB disease not present.

I have ☐ have not ☐ reviewed the above information with the parent/guardian.

Physician: _____ Date of Physical Exam: _____
Address: _____ Date This Form Completed: _____
Telephone: _____ Signature _____

☐ Physician ☐ Physician's Assistant ☐ Nurse Practioner